



Provider Satisfaction Survey

We would appreciate your feedback on our performance. The information you provide is a valued tool to improve our services and provide quality customer service. Please complete the survey, fold it in half and return it to ACS. Thank you for helping us to improve our service.

Provider Medicaid Number _____

Provider Name _____

Provider Type _____
(i.e., physician, hospital, etc.)

Provider Specialty _____

Contact Name _____

Phone Number _____

Survey Questionnaire

Rate ACS Provider Relations

5--Excellent 4--Good 3--Fair 2--Poor 1--Unacceptable

How professional and courteous were ACS employees during your calls?
Please explain your rating:

5 4 3 2 1

How knowledgeable were ACS employees regarding Medicaid information for your provider type?
Please explain your rating:

5 4 3 2 1

How completely were your questions answered?
Please explain your rating:

5 4 3 2 1

Were commitments made to you during the call completed timely?
Please explain your rating:

5 4 3 2 1

How would you rate the service you received overall?
Please explain your rating:

5 4 3 2 1

If your office has had a field visit, rate the quality of the field visit.
Please explain your rating:

5 4 3 2 1

If you attended a Montana Access to Health Web Portal training, rate the quality of the training.
Please explain your rating:

5 4 3 2 1

How does ACS compare to other payers for:

5--Excellent 4--Good 3--Fair 2--Poor 1--Unacceptable

Claim Processing Speed
Please explain your rating:

5 4 3 2 1

Problem claim resolution
Please explain your rating:

5 4 3 2 1

Customer Service
Please explain your rating:

5 4 3 2 1

Provider training
Please explain your rating:

5 4 3 2 1

Provider Information(i.e., Claim Jumper, Website, Manuals, Notices)
Please explain your rating:

5 4 3 2 1

Additional Comments Please:

**Place
Stamp
Here**

**Montana Medicaid
P.O. Box 4936
Helena, MT 59604**
